PRINTED: 12/20/2017

Division of Health Care Fa	cilities			FORM	APPROVE		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDI	TIPLE CONSTRUCTION	(X3) DAT	E BURVEY PLETED		
HAME OF STREET	TN7503	B, WING	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	12/20/2017			
NAME OF PROVIDER OR SUPPLIER	3 REELA	ADDRESS, CIT	Y, STATE ZIP CODE		20/2017		
DIVERSICARE OF SMYRNA	200 MAY	FIELD DRI	VE				
(X4) 10 SUMMARY ST.	ATEMENT OF OFFICIAL	A, TN 3716		22			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
N 000 Initial Comments		N 000	1	· · · · · · · · · · · · · · · · · · ·			
- 14/20/17 at Divers	was completed 12/18/17 icare of Symrna. Deficiencles hapter 1200-8-6, Standards for						
	Let's	1	N415	·			
(10) When licensure is applicable for a particular job, verification of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee.  Documentation that references were verified shall be on file. Documentation that all appropriate abuse registries have been checked shall be on file. Adequate medical screenings to exclude communicable disease shall be required of each employee.  This Rule is not met as evidenced by: Based on review of facility employee files and interview, the facility falled to ensure adequate medical screenings to exclude communicable diseases for 5 (#1, #2, #3, #4, #5) of 5 employee files reviewed.		N 415	All employee health files have been reviewed for TE screening and the offering with the acceptance or declination documentation for the Hepatitis B vaccinations.  All employees that were found to be lacking have been provided additional TB screening and the offering/information on the Hepatitis B vaccination has been provided to those employees. If accepted the vaccination was provided and is included in the employee health record. If the vaccination is declined, the signed declination form will be included in the employee health file.  The health screening/testing and vaccination offering and documentation for all new hires will be reviewed by the administrator and clinical educator to maintain continued compliance.				
The findings included:  Review of employee files revealed no documentation verifying the employees were free from tuberculosis for 5 of 5 employee files.  Further review revealed no documentation the employees were offered Hepatitis B vaccination or signed a declination for 4 (#1, #2, #4, #5) of 5 employee files.			The review of the employee healt reviewed during the center QAPI in educator will report at the QAPI in status of new hires health files. The by the Medical Director, Administr Clinical Educator, Dietary Manager Activities Director, Rehab Director, Supervisor, CNA and Business Office in the content of the	meeting. Theeting on a e QAPI is a ator, DNS, social Ser	ne clinical the trended ADNS, vices,		

Division of Health Care Facilities

I.ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(Xd) DATE

STATE FORM

GH7811

If continuation sheet 1 of 3

PRINTED: 12/29/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATÉ SURVEY COMPLETED	
	***	TN7503	B. WING	~~	400		
NAME OF	PROVIDER OR SUPPLIER	STREET AF		STATE, ZIP CODE		20/2017	
DIVEDSI	CARE OF SMYRNA	200 M AV	FIELD DRIV	STATE, ZIP CODE			
DIV (61701	CARE OF SINTRIA		TN 37167	<b>G</b>		9.0	
(X4) ID	SUMMARY STA	YEMENT OF DESIGNALES	dun.	CDC/ACTRIC SI ALL		*****	
PREFIX TAG	REGULATORY OR LO	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HULLUCE	(X5) COMPLET DATE	
N 415	Continued From pag	ge 1	N 415		· · · · · · · · · · · · · · · · · · ·	!	
1	Interview with the Ad	dministrator on 12/20/17 at					
	to ensure environment	e confirmed the facility falled s had adequate medical	į	NC47			
i	screening to exclude	e communicable diseases.		N643			
1				All employee health files hav	n hoor rout	عديما ٦	
N 643	1200-08-0606(3)(i)	Basic Services	N 643	evidence that the current flu	vaccine was	wed for	
				administered or offered and	declined	OHEIEG (	
:	influenza vaccinallor	shall have an annual program which shall include					
:	at least:	. program which shall include		All employees that were four	nd to be lacki	ng the	
i.	e <del>v</del> er ee saar			acceptance/declination docu	mentation ha	ava hoor	
į.	1. The offer of influence of influence of independent are	enza vaccination to all staff ctitioners at no cost to the		provided additional flu vaccin	ne informatio	n. If	
	beison of acceptance	e of documented evidence of		accepted the vaccination was	s provided an	d is	
100	raccination from ano	ther vaccine source or		included in the employee he	olth record, if	the	
1.7	acitty. The Nursing	Home will encourage all	1	vaccination is declined, the si	gned declina	tion forn	
ì	nfluenza vaccination	t practitioners to obtain an	}	will be included in the emplo			
12	2. A signed declinet	lon statement		Flu vaccines will continue to b	e offered thr	oughout	
9 E	A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a		ļ	the active flu season to all ne	all newly hired staff and the		
± 10				acceptance or declination do	cumentation	will be k	
1 20	ample form is availa	ble at nealth/topic/hcf-provider);		in the employee health file.			
1				The health screening/testing a	nd vaccinatio	n offerin	
13	. Education of all e	mployees about the	1	and documentation for all new			
110	bllowing:			by the administrator and clinic			
(i)	Flu vaccination,			maintain continued complianc employee health file audit will			
i (ii	) Non-vaccine contr	rol measures, and	1	the center QAPI meeting. The	clinical educa	tor will	
ii)	i) The diagnosis tra	nemission, and potential	1	report at the QAPI meeting on	the status of	new hire	
imi	pact of influenza;	Hely and botavital	1	health files. The QAPI is attend			
1	A =			Director, Administrator, DNS, A			
4. Va	An annual evaluati ccination program a	ion of the influenza		Educator, Dietary Manager, So	cial Services,	Activities	
no	n-participation; and	nd reasons for		Director, Rehab Director, Main	tenance Supe	er√isor,	
*		V/		CNA and Business Office Mana	Mer		

GM7811

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		APPRO	
*	IDENTIFICATION NUMBER:	A. GUILDING:		COM	(X3) DATE SURVEY COMPLETED	
	TN7503			401		
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE PIRCODE	121	20/2017	
DIVERSICARE OF SMYRNA	200 MAY	FIELD DRIVE	TATE, AIP CODE			
	SMYRNA	TN 37167				
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES  ACH DEPICIENCY MUST BE PREGEDED BY FULL  PREFIX  GULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS BESEDENCES  TAG  CROSS BESEDENCES		PROVIDER'S PLAN OF CORE	PRRECTION (X		
	SO IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AL	PPROPRIATE	CXS) COMPL DAT	
N 643 Continued From pa	ge 2	N 643	The same of the sa	***************************************	1	
5. A statement tha	it the requirements to	11040			ĺ	
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Commissioner or the	hortage as declared by the e Commissioner's designee.	1 1				
	o commonanter s designee.					
7	p.s.			1		
This Rule is not me	no nulden - cul					
i based on review of f	acility omniouss Ele-	1				
THE PREMIUM	Tallad to offer the !- e	1				
files reviewed.	#2, #3, #5) of 5 employee			j		
E-				1		
The findings included	1	ŀ		<u>\$</u>		
Review of employee	files revealed no			1		
influenza vaccination	employees were offered the or signed a declination.	(				
Interview with the Adr	ninistrator on 12/20/17 at					
E TOWN IN HIT HELDINGS	Confirmed the facility falled	1				
to offer the influen≿e v employees.	accination to 4 of 5	Į.		į į		
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